



ROI0502

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

FOR INTERNAL USE ONLY

MR # _____

ACCT # (most recent) _____

Date Received _____ Date Completed _____

Completed By _____

I authorize the release of protected health information to be disclosed and used by the following:

TO (Receiving Facility)

FROM (Releasing Facility)

Name: _____

Name: _____

Address: _____

Address: _____

City: _____

City: _____

State, Zip: _____

State, Zip: _____

Phone #: _____

Phone #: _____

Fax #: _____

Fax #: _____

Patient Name _____ Date of Birth _____

Address _____
Street City State Zip

Social Security Number _____ Daytime Phone Number _____

"I request to receive my medical records via:

- Pick-up
- US Postal Service/Mail
- Electronically; please provide e-mail address: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The type and amount of information to be used or disclosed is as follows, including dates:

REPORT TYPE	DATE(S)	REPORT TYPE	DATE(S)
<input type="checkbox"/> Facesheet	_____	<input type="checkbox"/> Progress Notes	_____
<input type="checkbox"/> Discharge Summary	_____	<input type="checkbox"/> Physician Orders	_____
<input type="checkbox"/> History & Physical	_____	<input type="checkbox"/> Lab Report	_____
<input type="checkbox"/> Emergency Dept Record	_____	<input type="checkbox"/> X-Ray Report	_____
<input type="checkbox"/> Consultation Report	_____	<input type="checkbox"/> Fetal Monitor Strip	_____
<input type="checkbox"/> Operative Report	_____	<input type="checkbox"/> Entire Record	_____
<input type="checkbox"/> Anesthesia/Surgery Report	_____	<input type="checkbox"/> Other, specify	_____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. The purpose for the use/disclosure of this information is:

- Patient/Personal Representative
- Physician Care
- Legal
- Insurance
- Other, specify _____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six (6) months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department or Privacy Officer.

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, Relationship to Patient

Signature of Witness

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Identification of Patient or Personal Representative:

- | | | |
|---|---|---|
| <input type="checkbox"/> Driver's License | <input type="checkbox"/> Social Security Number | <input type="checkbox"/> Power of Attorney |
| <input type="checkbox"/> Work Photo Badge | <input type="checkbox"/> Two Utility Bills | <input type="checkbox"/> Executor/Adm Estate |
| <input type="checkbox"/> Other Photo ID | <input type="checkbox"/> Notarized Signature | <input type="checkbox"/> StV Knows Individual |
| <input type="checkbox"/> Other, specify _____ | | |